

Claims Processing

Covered Topics

- Claim Forms
 - Paper
 - Electronic
- Remittance Advice
- Forms

Claim Forms

Paper Claim Forms

CMS1500 professional claim form

- www.nucc.org

UB-04 institutional claim form

- www.nubc.org

Both claim forms

- www.cms.hhs.gov

Includes field definitions and valid data for all fields

CMS 1500

Basic Requirements

- Client name
- Client ID (field 10d)
- Procedure and ICD-9 codes
- Date of service
- Place of service
- Usual and customary charges

CMS 1500

Basic Requirements

- Diagnosis pointer
- Rendering Provider NPI/Taxonomy
- Authorized signature and date
- Total charges
- Montana Health Care Programs NPI (field 33)

CMS 1500

Conditional Information

- Other insurance information
- Passport or Referral number
- Prior Authorization

UB-04

Basic Requirements

- Provider's physical address
- Type of bill
- From and through dates of service
- Client name
- Revenue codes
- Client status (box 17)
- Charges
- CPT-4/HCPCS codes

UB-04

Basic Requirements

- Creating date
- Payer name
- Pay-to NPI (form locator 56)
- Primary diagnosis
- Attending provider NPI and Taxonomy

UB-04

Conditional information

- Passport
- Admission (inpatient)
- Condition codes
- NDC
- Service dates
- Treatment authorization
- Admitting diagnosis (inpatient)

UB-04

- EMG
- Unlabeled (73) cost share indicator
- ICD-9 (inpatient only)
- Operating and other provider

Dental

Basic Requirements

- 2006 ADA form
- Complete the form in full
- Instructions can be found at
 - <http://www.ada.org>

Conditional Requirements

- Other coverage
- Orthodontics

Electronic Claims

Ways to submit claims

- Practice management software
- Billing agent
- Clearinghouse
- WINASAP5010 software

WINASAP5010

- Free software developed by Xerox
- Support offered by Xerox EDI: 406-457-9584
- Submit all claim types
 - Institutional
 - Professional
 - Nursing Home
 - Dental

Remittance Advice

Available every Tuesday

- Web portal
 - www.mtmedicaid.org
 - Available 90 days
 - Save or print option
- 835 transaction
 - ANSI X12 format
 - Requires software conversion
 - Offered via clearinghouse

Remittance Advice

Tips

- Work all denials before resubmitting
- Do not post payments in a credit balance
- Do not resubmit claims in a Pended status

Remittance Advice

1234567 Data, Test 07012011 07012011 1.000 99221 204.00 96.66
ICN 21122000000000000000 PATIENT NUMBER=10000

0000111111 Fred T Flinstone M D

07022011	07022011	1.000	59514	1900.00	0.00	B22	B13	M86	B15	M80
07032011	07032011	1.000	99231	93.00	0.00	B22				
07042011	07042011	1.000	99238	154.00	0.00	B22				

*****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE *****

B13 PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED
IN A PREVIOUS PAYMENT.

B15 PAYMENT ADJUSTED BECAUSE THIS PROCEDURE/SERVICE IS NOT PAID
SEPARATELY.

B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.

MA04 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR
PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER
NOT REPORTED OR WAS ILLEGIBLE.

M80 NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A
PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.

M86 SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE
WITHIN SET TIME FRAME.

N286 MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.

107 CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE
WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM

133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.

15 THE AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE
BILLED SERVICES OR PROVIDER.

18 DUPLICATE CLAIM/SERVICE.

22 THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.

9 THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE.



Healthy People. Healthy Communities.

Department of Public Health & Human Services

Forms

Found on the provider web page at
www.mtmedicaid.org

- Adjustment
- Blanket Denial
- Paperwork Attachment
- Address Change Request
- W-9
- Direct Deposit

Adjustment Form

How do I adjust a Claim?

- Download the adjustment from
- Paid claims
- Include a copy of the Remittance Advice

Montana Health Care Programs Medicaid • Mental Health Services Plan • Healthy Montana Kids Individual Adjustment Request

Instructions:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete only the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call Provider Relations at (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name and Address	3. Internal Control Number (ICN)
Fred Flinstone	21200000000000200
Name	
123 Main Street	4. NPI/API
Street or P.O. Box	1234567890
Somewhere MT 59601	5. Client ID Number
City State ZIP	5555555
2. Client Name	6. Date of Payment 06 01 2012
Kid Smith	7. Amount of Payment \$ 250.00

B. Complete only the items which need to be corrected.

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	05 01 12	5	3
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed – TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature *Sary Q* Date **07 01 2012**

When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:

Claims
P.O. Box 8000
Helena, MT 59604

Blanket Denial

- Codes/Procedures are never covered by the client's other insurance or Medicare
- Reviewed by the Xerox TPL unit
 - Fax request to 406-442-0357
- Valid for two years

What to submit with your claim

- Electronic claims: include pwk indicator
- Paper claims: submit only the claim



Request for Blanket Denial Letter State of Montana Medicaid

Effective Date Requested 07 01 2012 Provider/NPI 1234567890

Client Name Kid Smith

Medicaid ID Number 5555555

Name of Insurance Company on File BCBS

Procedure Codes Requested

1. 12345
2. _____
3. _____
4. _____
5. _____

Requesting Agency Main Street Clinic

Fax Number (406) 555-1555

Contact Person Suzy Q

Contact Phone Number (406) 555-5555

Number of Pages that Follow Request 2

Fax all requests to (406) 442-0357.

Request must include an explanation of benefits (EOB) stating the services are not covered.

Paperwork Attachments

- TPL explanation of benefits
- Medicare EOMB
- Blanket Denial Form



Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: 1234567890-5555555-06012012

Date of Service: 06 01 2012

Billing NPI/API: 1234567890

Client ID Number: 5555555

Type of Attachment: EOB

Instructions:

This form is used as a cover sheet for attachments to electronic and paper Montana Health Care Programs (Medicaid; Mental Health Services Plan; Healthy Montana Kids; Indian Health Services Program) claims sent to the address below.

The Paperwork Attachment Control Number must be the same number as the Attachment Control Number on the corresponding electronic claim. This number consists of the provider's NPI/API, the client's ID number and the date of service (mmddyyyy), each separated by a dash (NPI: 999999999-99999999-99999999/Atypical Provider ID: 999999-999999999-99999999).

This form may be copied or downloaded from the Provider Information website (<http://medicalprovider.hhs.mt.gov/>).

If you have questions about paper attachments that are necessary for a claim to process, call Provider Relations at (800) 624-3958 or (406) 442-1837.

Completed forms can be mailed or faxed to:
P.O. Box 8000
Helena, MT 59604
Fax: 1-406-442-4402

Address Correction

- Complete the form with updated information
- Indicate the type of change
- Include taxonomy codes

Provider Relations
P.O. Box 4938
Helena, MT 59604
(406) 442-1837 (Local)
1-800-624-3958 (In/Out of State)
(406) 442-4402 (Fax)



Address Correction Form

Physical address change requires a completed W-9.

Provider Number 1234567890 Taxonomy: 2JKL00000X

Passport Number
(if applicable)

Address 1 123 Main Street

Somewhere, MT 59601

☐ Physical Address

☒ Pay-To Address

☐ Correspondence

Address 2 1234567890 Taxonomy: 1BBG00000X

123 Main Street

Somewhere, MT 59601

☐ Physical Address

☒ Pay-To Address

☐ Correspondence

Phone Number (406) 555-5555

Fax Number (406) 555-1555

Authorized Signature

Suzy Q

Date

01/01/2012

Direct Deposit

- Complete all required sections
- Requires bankers signature
- Voided checks will not accepted

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for direct deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 (TO BE COMPLETED BY PAYEE)

A NAME OF PAYEE (last, first, middle initial) 		D TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS					
ADDRESS (street, route, P.O. Box, APO/FPO) 		E DEPOSITOR ACCOUNT NUMBER 					
CITY STATE ZIP CODE		F TYPE OF PAYMENT (Check only one) <input type="checkbox"/> Social Security <input type="checkbox"/> Fed Salary/Mil. Civilian Pay <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> Mil. Active <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Mil. Retiree <input type="checkbox"/> Civil Service Retirement (CSPM) <input type="checkbox"/> Mil. Survivor <input type="checkbox"/> VA Compensation or Pension <input type="checkbox"/> Other (specify)					
B NAME OF PERSON(S) ENTITLED TO PAYMENT 		G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY (if applicable) <table border="1"> <tr> <th>TYPE</th> <th>AMOUNT</th> </tr> <tr> <td></td> <td></td> </tr> </table>		TYPE	AMOUNT		
TYPE	AMOUNT						
C CLAIM OR PAYROLL ID NUMBER Prefix Suffix		JOINT ACCOUNT HOLDERS' CERTIFICATION (optional) I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.					
PAYEE/JOINT PAYEE CERTIFICATION I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.							
SIGNATURE	DATE	SIGNATURE	DATE				
SIGNATURE	DATE	SIGNATURE	DATE				

SECTION 2 (TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

NAME AND ADDRESS OF FINANCIAL INSTITUTION 		ROUTING NUMBER 		CHECK DIGIT
		DEPOSITOR ACCOUNT TITLE 		
FINANCIAL INSTITUTION CERTIFICATION I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.				
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE	

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

W-9

- Complete the form with current information
- Form version revised 2011

Form W-9 (Rev. December 2011) Department of the Treasury Internal Revenue Service	Request for Taxpayer Identification Number and Certification	Give Form to the requester. Do not send to the IRS.
Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate	
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C-C corporation, S-S corporation, P-partnership) ▶	
	<input type="checkbox"/> Other (see instructions) ▶	
	<input type="checkbox"/> Exempt payee	
Address (number, street, and apt. or suite no.)		Requester's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		
Part I Taxpayer Identification Number (TIN) Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3. Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.		
		Social security number <div style="border: 1px solid black; padding: 2px; display: flex; justify-content: space-between;"> </div>
		Employer identification number <div style="border: 1px solid black; padding: 2px; display: flex; justify-content: space-between;"> </div>
Part II Certification Under penalties of perjury, I certify that:		
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and		
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and		
3. I am a U.S. citizen or other U.S. person (defined below).		
Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.		
Sign Here	Signature of U.S. person ▶	Date ▶
General Instructions Section references are to the Internal Revenue Code unless otherwise noted.		
Purpose of Form A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:		
1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued), 2. Certify that you are not subject to backup withholding, or 3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.		
Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9. Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are: • An individual who is a U.S. citizen or U.S. resident alien, • A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, • An estate (other than a foreign estate), or • A domestic trust (as defined in Regulations section 301.7701-7). Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.		

Contact Information

Denise Juvik Field Representative

Phone 406-457-9598

Denise.juvik@xerox.com

Barbara Kamerzel Provider Relations Manager

Phone 406-457-9559

Barbara.kamerzel@xerox.com

Questions?